

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10833

Reg. Dist. No.

10848

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>C2 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>506 Pearre Ave.</u>				d. STREET ADDRESS <u>506 Pearre Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Elizabeth</u> Middle <u>Abernathy</u> Last			4. DATE OF DEATH <u>Oct.</u> Month <u>31</u> Day <u>19 59</u> Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> <u>July 30, 1895</u>			
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jessie Abernathy</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Randalls</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-01-1370A</u>		17. INFORMANT <u>Mrs. Ernest Abernathy-Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							
420.1 DUE TO <u>Coronary Sclerosis</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>Benedict Skitarelis</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Benedict Skitarelis, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>October 31, 1959</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>			
22d. LOCATION (City, town, or county) <u>Westernport</u>		(State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u>			ADDRESS <u>Westernport, Md.</u>				
24a. REC'D BY REGISTRAR <u>NOV 2 1959</u>		24b. REGISTRAR'S SIGNATURE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10849

CERTIFICATE OF DEATH

10834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 32 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 306 S. ALLEGANY STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle S. Last BARNES		4. DATE OF DEATH Month OCTOBER Day 3 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 28
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Insurance		10b. KIND OF BUSINESS OR INDUSTRY Insurance Co	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND BARNES		14. MOTHER'S MAIDEN NAME EMMA SCHWARTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
INFORMANT WARWICK & MEMORIAL AVENUE		MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Myocardial Fibrosis DUE TO (c) Coronary Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 5 Months ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auricular Fibrillation, Uremia, Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 59 , to Oct. 3 , 19 59 , that I last saw the deceased alive on Oct. 3 , 19 59 , and that death occurred at 2:27 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St. DATE SIGNED ACTUAL SIGNATURE DR. S. JACOBSON M.D. Cumberland, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/59	
22c. NAME OF CEMETERY OR CREMATORY Reform Ch. Cem.		22d. LOCATION (City, town, or county) (State) Parkside Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR OCT 6 '59	
ADDRESS Cumb. Md.		24b. REGISTRAR'S SIGNATURE Arthur G. Kline	

1983

CENTRAL OF DEATH

1983

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CERTIFICATE OF DEATH

Reg. Dist. No.

10850

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 454 Pennsylvania Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT HENRY BATIE				4. DATE OF DEATH Month October Day 28 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 21, 1875	
9. AGE (In years lost birthday) yrs. 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Batie				14. MOTHER'S MAIDEN NAME Emma Funk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 205-09-8670			
17. INFORMANT Mrs. Walter Hillegass				18. ADDRESS (Street, city or town, state) 454 Penn. Avenue Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) myocardial Decompensation (c) 2 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 52 to Oct 28 , 19 59 , that I last saw the deceased alive on Oct. 27 , 19 59 , and that death occurred at 9:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett				ADDRESS (Street, city or town, state) 236 Va Ave DATE SIGNED October 31, 1959			
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D.				23b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 31, 1959			
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE NOV 2 '59			

10832

CENTRAL STATE OF DEPT.

10832

Allegany

Marshall

Allegany

Chesapeake

1 year

Chesapeake

104 Pennsylvania Avenue

104 Pennsylvania Avenue

October 22, 1933

DATE

RECEIVED

RECEIVED

November 21, 1933

RECEIVED

Westport, Maryland

H. O. Railroad

Westport, Maryland

104 Penn. Avenue

Room

Room

Room

Chesapeake, Maryland

305-09-3570 Inc. Walter Halligan

October 21, 1933

230 Virginia Ave, Chesapeake, Md.

Clark E. Barrett

Chesapeake, Maryland

104. 31, 1933 Home Mail Company

Home Mail Company

John J. Baker, Chesapeake, Maryland

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10836

10851

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland 02</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Memorial Hospital</u>		d. STREET ADDRESS <u>609 Henderson Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Lewis Bealky</u>		4. DATE OF DEATH Month Day Year <u>October 2 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16, 1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Bealky</u>		14. MOTHER'S MAIDEN NAME <u>Anna Kiiffner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-9517</u>	
17. INFORMANT <u>Mrs. Hilda Bealky</u>		609 Henderson Ave, <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary sclerosis with thrombosis, right</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> *****			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>October 3, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland (Rural)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '59</u>	
ADDRESS <u>Cumberland Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10852

10837

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 735 Oldtown Road	
3. NAME OF DECEASED (Type or print) WILLIAM HENRY BOWERS		4. DATE OF DEATH Month October Day 14 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1873
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Store Manager	
11. BIRTHPLACE (State or foreign country) Bloomery Furnace, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bowers		14. MOTHER'S MAIDEN NAME Betty Furrel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Hugh W. Burke		735 Oldtown Road Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 CONTUSION OF BRAIN, SUBDURAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FALL DOWN STEPS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Days 3 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell Down Steps at Daughter's house-Harding, W.Va.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:30 P. 10/9/59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Harding, West Virginia	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 14, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/59	
22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		22d. LOCATION (City, town, or county) (State) Elkins, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DCT 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hafer	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10838

10901

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sand Spring		d. STREET ADDRESS Sand Spring	
3. NAME OF DECEASED (Type or print) CLARA First Middle Last MICHAELS BRODE		4. DATE OF DEATH 10 Month 24 Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-4-1887
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Michael		14. MOTHER'S MAIDEN NAME Margaret McBride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. George Phillips, Sand Spring,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular disease. 443X DUE TO (b) 3-4 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-1 , 19 58 to 10-24 , 19 59 , that I last saw the deceased alive on 10-24 , 19 59 , and that death occurred at 8 a. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H.C. Diehl M.D.		ADDRESS (Street, city or town, state) 39 W. Main St. Frostburg, Md.	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.		DATE SIGNED 10/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-26-59	22c. NAME OF CEMETERY OR CREMATORY Hansel Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home ADDRESS 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR OCT 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

10033

10033

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>		<p>4. Place of birth: <u>Johns Hopkins</u></p>	
<p>5. Date of death: <u>Jan 1, 1950</u></p>		<p>6. Place of death: <u>Johns Hopkins</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	
<p>13. Signature of funeral director: <u>John Doe</u></p>		<p>14. Signature of undertaker: <u>John Doe</u></p>	
<p>15. Signature of cemetery: <u>John Doe</u></p>		<p>16. Signature of burial: <u>John Doe</u></p>	
<p>17. Signature of interment: <u>John Doe</u></p>		<p>18. Signature of cremation: <u>John Doe</u></p>	
<p>19. Signature of other: <u>John Doe</u></p>		<p>20. Signature of other: <u>John Doe</u></p>	
<p>21. Signature of other: <u>John Doe</u></p>		<p>22. Signature of other: <u>John Doe</u></p>	
<p>23. Signature of other: <u>John Doe</u></p>		<p>24. Signature of other: <u>John Doe</u></p>	
<p>25. Signature of other: <u>John Doe</u></p>		<p>26. Signature of other: <u>John Doe</u></p>	
<p>27. Signature of other: <u>John Doe</u></p>		<p>28. Signature of other: <u>John Doe</u></p>	
<p>29. Signature of other: <u>John Doe</u></p>		<p>30. Signature of other: <u>John Doe</u></p>	
<p>31. Signature of other: <u>John Doe</u></p>		<p>32. Signature of other: <u>John Doe</u></p>	
<p>33. Signature of other: <u>John Doe</u></p>		<p>34. Signature of other: <u>John Doe</u></p>	
<p>35. Signature of other: <u>John Doe</u></p>		<p>36. Signature of other: <u>John Doe</u></p>	
<p>37. Signature of other: <u>John Doe</u></p>		<p>38. Signature of other: <u>John Doe</u></p>	
<p>39. Signature of other: <u>John Doe</u></p>		<p>40. Signature of other: <u>John Doe</u></p>	
<p>41. Signature of other: <u>John Doe</u></p>		<p>42. Signature of other: <u>John Doe</u></p>	
<p>43. Signature of other: <u>John Doe</u></p>		<p>44. Signature of other: <u>John Doe</u></p>	
<p>45. Signature of other: <u>John Doe</u></p>		<p>46. Signature of other: <u>John Doe</u></p>	
<p>47. Signature of other: <u>John Doe</u></p>		<p>48. Signature of other: <u>John Doe</u></p>	
<p>49. Signature of other: <u>John Doe</u></p>		<p>50. Signature of other: <u>John Doe</u></p>	
<p>51. Signature of other: <u>John Doe</u></p>		<p>52. Signature of other: <u>John Doe</u></p>	
<p>53. Signature of other: <u>John Doe</u></p>		<p>54. Signature of other: <u>John Doe</u></p>	
<p>55. Signature of other: <u>John Doe</u></p>		<p>56. Signature of other: <u>John Doe</u></p>	
<p>57. Signature of other: <u>John Doe</u></p>		<p>58. Signature of other: <u>John Doe</u></p>	
<p>59. Signature of other: <u>John Doe</u></p>		<p>60. Signature of other: <u>John Doe</u></p>	
<p>61. Signature of other: <u>John Doe</u></p>		<p>62. Signature of other: <u>John Doe</u></p>	
<p>63. Signature of other: <u>John Doe</u></p>		<p>64. Signature of other: <u>John Doe</u></p>	
<p>65. Signature of other: <u>John Doe</u></p>		<p>66. Signature of other: <u>John Doe</u></p>	
<p>67. Signature of other: <u>John Doe</u></p>		<p>68. Signature of other: <u>John Doe</u></p>	
<p>69. Signature of other: <u>John Doe</u></p>		<p>70. Signature of other: <u>John Doe</u></p>	
<p>71. Signature of other: <u>John Doe</u></p>		<p>72. Signature of other: <u>John Doe</u></p>	
<p>73. Signature of other: <u>John Doe</u></p>		<p>74. Signature of other: <u>John Doe</u></p>	
<p>75. Signature of other: <u>John Doe</u></p>		<p>76. Signature of other: <u>John Doe</u></p>	
<p>77. Signature of other: <u>John Doe</u></p>		<p>78. Signature of other: <u>John Doe</u></p>	
<p>79. Signature of other: <u>John Doe</u></p>		<p>80. Signature of other: <u>John Doe</u></p>	
<p>81. Signature of other: <u>John Doe</u></p>		<p>82. Signature of other: <u>John Doe</u></p>	
<p>83. Signature of other: <u>John Doe</u></p>		<p>84. Signature of other: <u>John Doe</u></p>	
<p>85. Signature of other: <u>John Doe</u></p>		<p>86. Signature of other: <u>John Doe</u></p>	
<p>87. Signature of other: <u>John Doe</u></p>		<p>88. Signature of other: <u>John Doe</u></p>	
<p>89. Signature of other: <u>John Doe</u></p>		<p>90. Signature of other: <u>John Doe</u></p>	
<p>91. Signature of other: <u>John Doe</u></p>		<p>92. Signature of other: <u>John Doe</u></p>	
<p>93. Signature of other: <u>John Doe</u></p>		<p>94. Signature of other: <u>John Doe</u></p>	
<p>95. Signature of other: <u>John Doe</u></p>		<p>96. Signature of other: <u>John Doe</u></p>	
<p>97. Signature of other: <u>John Doe</u></p>		<p>98. Signature of other: <u>John Doe</u></p>	
<p>99. Signature of other: <u>John Doe</u></p>		<p>100. Signature of other: <u>John Doe</u></p>	

10033

10853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 80yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 South Street		d. STREET ADDRESS 110 South Street	
3. NAME OF DECEASED (Type or print) First Middle Last Oliver Franklin Brown		4. DATE OF DEATH IO - 3 - 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1870
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dye & Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Troft Valley, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Brown		14. MOTHER'S MAIDEN NAME Lavina McMullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT James Wright		Address 110 South St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 DUE TO Uraemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1959 to Oct. 3, 1959 , that I last saw the deceased alive on Oct. 1, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland DATE SIGNED 10/5/59	
PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-6-59	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR OCT 8 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

293

5021



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10902

CERTIFICATE OF DEATH

Reg. Dist. No.

10840

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 420 MARYLAND AVE.				d. STREET ADDRESS 420 MARYLAND AVE.			
3. NAME OF DECEASED (Type or print) First LEONORA Middle L. Last BURNS				4. DATE OF DEATH Month OCTOBER Day 26 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 25, 1905	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY C & P TEL. CO.		11. BIRTHPLACE (State or foreign country) PIEDMONT, W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM F. BURNS				14. MOTHER'S MAIDEN NAME ELIZABETH STUDD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 233-10-1139		17. INFORMANT MRS. FRANCIS HANNON, WESTERNPORT, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Lung DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 18 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from past 19 to 10 weeks , 19 19 , that I last saw the deceased alive on 10/25 , 19 57 , and that death occurred at 6:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED PAUL T. HEALY M.D. OCT. 26 '59							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF OCT. 29/59		22c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY	
22d. LOCATION (City, town, or county) (State) WESTERNPORT, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Fredrickson				ADDRESS PIEDMONT, W.VA.		24a. REC'D BY REGISTRAR DATE OCT 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines							

CERTIFICATE OF DEATH

10902

and DOW 100

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF BURIAL OFFICIAL</p> <p>21. SIGNATURE OF FUNERAL HOME</p> <p>22. SIGNATURE OF CHURCH</p> <p>23. SIGNATURE OF CEMETERY</p> <p>24. SIGNATURE OF OTHER</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10841

10914

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian		c. LENGTH OF STAY IN 1b lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET			First Middle Last CECIL		4. DATE OF DEATH Month 10 Day 28 Year 19 59.		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1879		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Mineral County, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank T. Smith				14. MOTHER'S MAIDEN NAME Rebecca Leatherman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address William Cecil, Midlothian, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 16, 1959 , to Oct 28, 1959 , that I last saw the deceased alive on Oct 16, 1959 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMC Lane M.D.				ADDRESS (Street, city or town, state) Frostburg DATE SIGNED 10/28/59			
PHYSICIAN'S NAME (Type) WOMC Lane MD				md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-59		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park, Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paul H. Montesant Hafer Funeral Home 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10842

10903

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle E. Last CONNOR		4. DATE OF DEATH Month OCT. Day 7 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitters Helper		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN CONNOR		14. MOTHER'S MAIDEN NAME MARGARET EWING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-01-3730	
17. INFORMANT HAROLD CONNOR, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 DUE TO Gr Heart Failure - Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 yrs 32 -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. X p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE , 19 56 , to OCT. 7 , 19 59 that I last saw the deceased alive on OCT. 7 , 19 59 , and that death occurred at 8:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin Rothstein		DATE SIGNED BROADWAY	
PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		FROSTBURG, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-10-1959	22c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY	22d. LOCATION (City, town, or county) (State) FROSTBURG, MD.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST,		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
ADDRESS FROSTBURG, MD.		24b. REGISTRAR'S SIGNATURE Arthur J. Hanna	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10843

10854

CERTIFICATE OF DEATH

Items 3 & 4 Film G250 10/22/59 1wk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 21 Boone Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Resley Catherine Cope				4. DATE OF DEATH Month Day Year Oct. 15 1959											
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 21, 1879		9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Peter Cosgrove				14. MOTHER'S MAIDEN NAME Martha Judy											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Lawlyn Cope Cumberland, Md. (Son) Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditic Decomposition - 1 hr DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 5, 1959 , to Oct. 14, 1959 , that I last saw the deceased alive on Oct. 13, 1959 , and that death occurred at 9:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 236 Va. Ave. Cumberland 9/16/59															
ACTUAL SIGNATURE Clay E. Durrett M.D.				PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave. Cumberland, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-17-59		22c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery		22d. LOCATION (City, town, or county) (State) Dansville, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md. ADDRESS						24a. REC'D BY REGISTRAR DATE OCT 20 1959		24b. REGISTRAR'S SIGNATURE C. L. S. K...							

CERTIFICATE OF DEATH

10051

WILLIAM
B. CAMPBELL
BIRMINGHAM

Form with multiple lines for text entry, including fields for name, date, and other details. The form is partially filled out with handwritten text.

NAME: WILLIAM B. CAMPBELL
BIRMINGHAM

DATE: 11-17-54

AGE: 68

SEX: M

RACE: W

EDUCATION: HS

OCCUPATION: RETIRED

CAUSE OF DEATH: HEART DISEASE

DATE OF DEATH: 11-17-54

PLACE OF DEATH: HOME

SIGNATURE: [Signature]

DATE: 11-17-54

10915

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Nr. Cumberland			c. LENGTH OF STAY IN 1b years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 4, Box #72 Oldtown Road			d. STREET ADDRESS Route 4, Box #72 Oldtown Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELWOOD CRABTREE			4. DATE OF DEATH Month October Day 4 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1884		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Yardman		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	11. BIRTHPLACE (State or foreign country) Oldtown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Crabtree			14. MOTHER'S MAIDEN NAME Lydia Moreland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. INFORMANT		
17. ADDRESS Rt. 4, Box #72 Oldtown			Mrs. Bertha Crabtree Road, Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis in Decem (c) poisonation					INTERVAL BETWEEN ONSET AND DEATH 6 weeks 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June , 19 57 , to Oct 4 , 19 59 , that I last saw the deceased alive on Oct 21 , 19 57 , and that death occurred at 5:00 P. M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Clay E. Durrett		M.D. 2366 1/2 Cumberland		DATE SIGNED 10/6/59	
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D.		236 Virginia Ave. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS 24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur A. Kraus	
		DATE OCT 8 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

Allegany

Maryland

Number

Allegany

Post-Office, near Chambersburg

Years

John H. Chambersburg

John H. Chambersburg

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1925

NAME OF DECEASED: [illegible]
RESIDENCE: [illegible]
DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]
PLACE OF EXAMINATION: [illegible]

NAME OF EXAMINER: [illegible]
ADDRESS: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF EXAMINATION: [illegible]

PLACE OF EXAMINATION: [illegible]

NAME OF EXAMINER: [illegible]

ADDRESS: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY Bedford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEDFORD RD # 3 75 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #3 Bedford	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First INEZ Middle E. Last DICKEN		4. DATE OF DEATH Month OCTOBER Day 6 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ROHRBAUGH		14. MOTHER'S MAIDEN NAME WISE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT WARWICK MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 day			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 5, 1959 to Oct 6, 1959 , that I last saw the deceased alive on Oct 5, 1959 , and that death occurred at 11:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett		ADDRESS (Street, city or town, state) 236 Valley Cemetery DATE SIGNED 10/6/59	
PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 10/9/59	
22c. NAME OF CEMETERY OR CREMATORY Husband Cen.		22d. LOCATION (City, town, or county) (State) Somerset, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.		24a. REC'D BY REGISTRAR DATE OCT 9 '59	
24b. REGISTRAR'S SIGNATURE Calvin L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10850

ALBANY

PENNSYLVANIA

CHICAGO

1 DAY

DECEASED

CHICAGO HOSPITAL

RT. 43

1125

E.

DICTION

OCTOBER

WHITE

JULY 30

11

HOUSEWIFE

PENNSYLVANIA

WILLIAM BOMBARDIER

1125

CHICAGO HOSPITAL - CHICAGO, ILLINOIS

1

DR. CLAY E. DUNSTON

James Alexander Grant MD
11/15/11
11/15/11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10847

10857

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barrellsville, Rt. # 1 Mt. Savage	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Sacred Heart Hosp.		d. STREET ADDRESS Along State Rt. # 47	
3. NAME OF DECEASED (Type or print) First CLYDE Middle DIEHL Last DIEHL		4. DATE OF DEATH Month October Day 30 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1910
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron worker, Rodman		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Little Orleans, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry D. Diehl		14. MOTHER'S MAIDEN NAME Pearl E. Twigg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-6736	
17. INFORMANT Mrs. Anna L. Diehl		Address Rt. # 1 Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/59	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10858

CERTIFICATE OF DEATH

Reg. Dist. No.

10848

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 454 Pine Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle R. Last Dorsey				4. DATE OF DEATH Month 10 Day 18 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-17-1904	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 18 Hours 18 Min.		IF UNDER 24 HRS. Months 5 Days 18 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher				10b. KIND OF BUSINESS OR INDUSTRY Own Restaurant		11. BIRTHPLACE (State or foreign country) Maryland Cumberland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Wesley Dorsey				14. MOTHER'S MAIDEN NAME Anna P. Taper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-12-8511			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Gangrene, right leg DUE TO (c) 3 weeks				INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-27-59 to 10-18-59 that I last saw the deceased alive on 10-18-59 , and that death occurred at 10-18-59 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. T. Johnson				ADDRESS (Street, city or town, State) 16 Greene St Cumberland Md			
PHYSICIAN'S NAME (Type) J. T. Johnson M.D.				DATE SIGNED 10-22-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR OCT 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10823

Robertson

Two Restaurant

John P. Taylor

John Taylor

11-12-11

John P. Taylor

11-12-11

John P. Taylor

11-12-11

John P. Taylor

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10859

CERTIFICATE OF DEATH

Reg. Dist. No.

10849

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle M. Last FLETCHER		4. DATE OF DEATH Month OCTOBER Day 24 Year 19 59	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 6	
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES ADAMS		14. MOTHER'S MAIDEN NAME GENEVA MC KEWEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles Fletcher Cumberland Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio vas. dis. DUE TO (c) Arrhythmia Fibrillation		INTERVAL BETWEEN ONSET AND DEATH 11 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10.13.19.59 to 10.24.19.59 that I last saw the deceased alive on 10.23.19.59 , and that death occurred at 7:00A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 10.24.59	
ACTUAL SIGNATURE W. F. Williams		PHYSICIAN'S NAME (Type) W. F. WILLIAMS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.26.59	
22c. NAME OF CEMETERY OR CREMATORY Piney Plains		22d. LOCATION (City, town, or county) (State) Little Orleans Allegany Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone		ADDRESS Howard J. Stone	
24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

10849

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.
JAMES EARL RAY
WHITE
MALE
BORN 10.26.34
FLEETCHER
OCTOBER 29
LITTLE ROCK, ARK.
MAYLAND
GENEVA M. MOORE
U.S.A.

10860

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>233 Kraft Place</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>V.</u> Last <u>Glover</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1896</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland - Rawlings</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Leanna Shepherd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
INFORMANT <u>Patient</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA LUNG</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure - Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6.21.57</u> , 19 <u> </u> , to <u>10.31.59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10.31.59</u> , 19 <u> </u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>441 N. CENTRE ST. CUMBERLAND, MD.</u> DATE SIGNED <u>11.2.59</u>			
ACTUAL SIGNATURE <u>W. P. James</u> M.D.		PHYSICIAN'S NAME (Type) <u>Dr. W.P. James.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-3-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100880

DEPARTMENT OF HEALTH

100880

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "REPORT", "DATE", and "BY" are faintly visible.]

10882

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar	
John Doe		Male		45		10/15/1910		New York City		New York City		Heart Disease		Natural		Teacher		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Usual Residence		Cause of Death		Manner of Death		Occupation		Signature of Physician		Signature of Registrar		Date of Report		Place of Report	
10/20/1955		10:00 AM		New York City		New York City		Heart Disease		Natural		Teacher		[Signature]		[Signature]		10/25/1955		New York City	

10882

10882

10862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3½ HRS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				d. STREET ADDRESS RT.#3 BEDFORD ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle L. Last GRAPES				4. DATE OF DEATH Month OCTOBER Day 19 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10, 1901		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.	IF UNDER 24 HRS. Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Mfg				10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.		11. BIRTHPLACE (State or foreign country) W.VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JAMES GRAPES			
14. MOTHER'S MAIDEN NAME VIRGINIA SOWERS				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 214-07-0345				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 10/19 , 19 59 , to 10/19 , 19 59 , that I last saw the deceased alive on 10/19 , 19 59 , and that death occurred at 8:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley Jr.				ADDRESS (Street, city or town, state) 452 N. Center St. Cumberland, Md.			
PHYSICIAN'S NAME (Type) LEO H. LEY JR.				DATE SIGNED 10/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/21/59		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	
22d. LOCATION (City, town, or county) Cumberland Maryland				22e. (State) (Rural)		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR OCT 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hearn				24c. DATE OCT 23 '59		24d. (State)	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10882

CERTIFICATE OF DEATH

10882

ALLIANCE

HAYWARD

HAYWARD

HAYWARD

HAYWARD

HAYWARD

HAYWARD

AT 1234 BAYVIEW RD.

HAYWARD, CALIF.

OCTOBER 19

HAYWARD

HAYWARD

HAYWARD

HAYWARD

HAYWARD

HAYWARD

U.S.A.

HAYWARD

HAYWARD

HAYWARD

HAYWARD

HAYWARD

HAYWARD, CALIF.

HAYWARD HOSPITAL

HAYWARD

HAYWARD

HAYWARD, CALIF.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10904

CERTIFICATE OF DEATH

10853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg d. STREET ADDRESS 35 West College Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle MARTIN Last HARTIG		4. DATE OF DEATH Month October Day 10 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1881 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat business	
11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Hartig		14. MOTHER'S MAIDEN NAME Catherine Dilfer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Emma Hartig		Address Frostburg, Md. 35 W. College Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive Cardio-vascular disease DUE TO (b) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-1-55 19 55 , to 10-10 19 59 , that I last saw the deceased alive on 10-10 19 59 , and that death occurred at 2 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. C. Diehl		ADDRESS (Street, city or town, state) 39 W. Main St.	
PHYSICIAN'S NAME (Type) H. C. Diehl, M.D.		DATE SIGNED 10/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-13-59	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg	22d. LOCATION (City, town, or county) (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Benah H. Montague		ADDRESS 23 E. Main, Frostburg, Md.	
24a. REC'D BY REGISTRAR Oct 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 50 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG		d. STREET ADDRESS 66 W. COLLEGE AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle A. Last HITCHINS		4. DATE OF DEATH Month OCT. Day 11, Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 2, 1883
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. STOREROOM CLERK		10b. KIND OF BUSINESS OR INDUSTRY KELLY-SPG. TIRE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HITCHINS		14. MOTHER'S MAIDEN NAME SALLIE BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-10-6621	
17. INFORMANT MRS. RACEHL DUNN, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Cardio-Vascular, Renal Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mo		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 9, 1959 to Oct 11, 1959 , that I last saw the deceased alive on Oct 11, 1959 , and that death occurred at 1800p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. MAIN ST., FROSTBURG, MD. DATE SIGNED Oct 12 1959 ACTUAL SIGNATURE W O McLane M.D. PHYSICIAN'S NAME (Type) W. O. McLANE, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 14 '59	
22c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST,		24a. REC'D BY REGISTRAR Oct 15 '59	
ADDRESS FROSTBURG, MD.		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

10000

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10863

CERTIFICATE OF DEATH

10855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle J. Last JOHNS		4. DATE OF DEATH Month OCTOBER Day 11 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 2, 1896
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Fixer		10b. KIND OF BUSINESS OR INDUSTRY Gelanese Corp.	
11. BIRTHPLACE (State or foreign country) WALES, ENGLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACK J. JOHNS		14. MOTHER'S MAIDEN NAME SARAH MORGAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW 1 217-10-7407	
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation DUE TO (c) Chronic Myocarditis - old Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 54 , to Oct , 19 59 , that I last saw the deceased alive on Oct 11 , 19 59 , and that death occurred at 1:20 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Virginia Ave DATE SIGNED 10/8/59			
ACTUAL SIGNATURE G. O. Himmelwright M.D.		PHYSICIAN'S NAME (Type) G. O. Himmelwright M.D. Cumberland, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY Davis Mem. Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR OCT 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

John J. Baker, Cumberland, Maryland

October 14, 1900 (Main News Company)
Allentown County, Maryland

Handwritten notes:
Oct 14 - 1900
C. C. Thompson
C. C. Thompson

217-10-7407
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

JACK J. JOHNS
CHAS. MORGAN

WALTON, ENGLAND
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FEBRUARY 2, 1898

DAVID
JONES
OCTOBER

MEMORIAL HOSPITAL
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BIRTHPLACE OF DEATH

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10864

CERTIFICATE OF DEATH

10856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/25/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle Smith Last Jones		4. DATE OF DEATH Month October Day 2 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/1870
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.	11. IF UNDER 24 HRS. Months 8 Days 8 Hours 8 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Auto Mechanic & W/Md. RR		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Jones		14. MOTHER'S MAIDEN NAME Mary Litzenberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/25/59 , 19____, to 10/2/59 , 19____, that I last saw the deceased alive on 10/2/59 , 19____, and that death occurred at 6:30P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 10/3/59			
ACTUAL SIGNATURE James E. McLean M.D.		DATE SIGNED 10/3/59	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/5/59	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 6 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

10857

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Madeline Last Kaiser		4. DATE OF DEATH Month 10/ Day 1/ Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1911
9. AGE (In years last birthday) 48 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assist. cook	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward P Cosgrove		14. MOTHER'S MAIDEN NAME Margaret Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-7200	
17. INFORMANT Mr. Walter C. Kaiser		Address 113 Wills Creek Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) apoplectic stroke 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterial hypertension DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 hours 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 9-30 , 19 59 , to 10-1 , 19 59 , that I last saw the deceased alive on 9-30 , 19 59 , and that death occurred at 3:25A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE L. Brings M.D. Cumberland, Md. 10/2/59 PHYSICIAN'S NAME (Type) Dr. L. Brings 57 Green Street			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/5/59	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		24a. REC'D BY REGISTRAR DATE OCT 6 '59	
ADDRESS Cumberland, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10837

CERTIFICATE OF DEATH

CHIEF CLERK

18-0-4002

10866 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROLLAND Middle H. Last KASKE				4. DATE OF DEATH Month OCTOBER Day 11 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 7,	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chem. Ass't				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM KASKE				14. MOTHER'S MAIDEN NAME SOPHIA RANK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214 07 5044			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Rectum DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 12 mos 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 57 , 19 57 , to Oct 11 , 19 59 , that I last saw the deceased alive on Aug 12 , 19 59 , and that death occurred at 7 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 10-14-59							
ACTUAL SIGNATURE William P. James M.D.							
PHYSICIAN'S NAME (Type) DR/ W. P. JAMES.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR OCT 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUCE KANE

COMMERCIAL, MD.

Oct. 11, 1952 General Hospital, Baltimore, Md.

DR. W. F. JAMES.

1/11/52

ALL BY BONE MEMORIAL HOSPITAL, COMMERCE, MD.

WILLIAM JONES

SEPHIA RAY

WILLIAM JONES

COLLEGE CORP.

WILLIAM JONES

WILLIAM JONES

WILLIAM JONES

ROLLING

WILLIAM JONES

OCTOBER 11

MEMORIAL HOSPITAL, MEMORIAL & MARKING

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WILLIAM JONES

COMMERCIAL

1952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10867

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Summerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meyersdale</u> <u>75X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp.</u>				d. STREET ADDRESS <u>311 Thomas St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Margaret</u> Last <u>KEEGAN</u>				4. DATE OF DEATH Month <u>10-16-</u> Day <u>159</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1883</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Cox</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth McKenzie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Michael Keegan Meyersdale</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> (a), stating the underlying cause lost. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> b) <u> </u> c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		October 16, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Philip & James</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Rush</u>		ADDRESS <u>Meyersdale Pa</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10868

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRED Middle Last KERSHNER				4. DATE OF DEATH Month OCTOBER Day 1 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 13, 1905	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES KERSHNER				14. MOTHER'S MAIDEN NAME EDNA SWITZER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-5525		INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X DUE TO Cox Pulmonale Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Fibrosis + Emphysema DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/28 , 19 59 , to 10/1 , 19 59 , that I last saw the deceased alive on 10/1 , 19 59 , and that death occurred 10:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley		M.D. 456 N. Center St		ADDRESS (Street, city or town, state) Cumberland Md		DATE SIGNED 10/3/59	
PHYSICIAN'S NAME (Type) LEO H. LEY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-59		22c. NAME OF CEMETERY OR CREMATORY St Paul Luth. Reformed Cem Clearspring, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR OCT 6 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10800

CENTRAL CAUSE OF DEATH

JUNE 1943

ALLIANCE

MARYLAND

MARYLAND

ALLIANCE

MARYLAND

2 DAYS

CORPSE

30 WEST CUMMINS ST.

MEMORIAL HOSPITAL
MEMORIAL & MARSH AVE.

MEMORIAL HOSPITAL

FROM

MAY 19 1943

MALE WHITE

MARYLAND

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS HOSPITAL

ST. LOUIS

ST. LOUIS

10869

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 20 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR MEMORIAL HOSPITAL				d. STREET ADDRESS 85x3			
3. NAME OF DECEASED (Type or print) First MARGIE Middle M. Last KUH				4. DATE OF DEATH Month OCTOBER Day 17 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 13	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES MC NEIL				14. MOTHER'S MAIDEN NAME MARY HILKEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. WARWICK & MEMORIAL AVENUE			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 603X DUE TO Plumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lower respiratory system DUE TO 8 days (c) L. Myocardium DUE TO 9 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 27 Sept., 1959 , to 17 Oct., 1959 , that I last saw the deceased alive on 17 Oct., 1959 , and that death occurred at 2:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James B. Stegmaier M.D. 122 do Arline St, Cumberland Md. 20 Oct 59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DR. J. STEGMAIER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 19 Oct 59		22c. NAME OF CEMETERY OR CREMATORY Maysville		22d. LOCATION (City, town, or county) (State) Maysville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Allen M. Potluck				ADDRESS Keyser, W. Va.		24a. REC'D BY REGISTRAR DATE OCT 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoms			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1989

CERTIFICATE OF DEATH

MINERAL

WEST VIRGINIA

LAVELLE

50 DAYS

MEMORIAL HOSPITAL

OCTOBER 1989

MAY

M.

MARGIE

63

SEPTEMBER 13

WHITE

FEMALE

U.S.A.

WEST VIRGINIA

HOUSEWIFE

HARRY HILNEY

CHARLES MC JILL

MINERAL & MEMORIAL AVENUE

MEMORIAL HOSPITAL - CEMETERY, W.V.

DR. J. STEINER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10862

CERTIFICATE OF DEATH

Reg. Dist. No.

10870

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give name of place where death occurred) OR INSTITUTION MEMORIAL HOSPITAL WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAST XXX LEASURE, C. FIRST XXX ROBERT				4. DATE OF DEATH Month OCTOBER Day 22 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 15, 1900	
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. SA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Railway Express			
13. FATHER'S NAME LEASURE, ROBERT				14. MOTHER'S MAIDEN NAME ROBINETTE, MELISSA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 3 24.5
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 10-21 , 19 59 , to 10-22 , 19 59 , that I last saw the deceased alive on 10-22 , 19 59 , and that death occurred at 4:35 PM , from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE William P. James M.D.				4414 G. St. 10-26-59			
PHYSICIAN'S NAME (Type) DR. W. P. JAMES MD.				Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/59		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Hafer				ADDRESS Cumberland Md.		24a. REC'D BY REGISTRAR DATE OCT 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Haines							

we are all
very much
interested in
the progress of
the work

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10863

CERTIFICATE OF DEATH

10906

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Frostburg		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg (Rural)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital				STREET ADDRESS R.F.D. #1		(If rural give location)	
3. NAME OF DECEASED (Type or Print) CATHERINE M. LEPTIC				4. DATE OF DEATH (Month) (Day) (Year) 10/17/1959 19			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 2/19/1884	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ----- Konrad				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Frostburg, MD. Miss Ann Leptic, R.F.D. #1			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) Chr Nephritis Uremia						2 mo	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June , 19 59 , to Oct 17 , 19 59 , that I last saw the deceased alive on Oct 17 , 19 59 , and that death occurred at 2:20 PM , from the causes and on the date stated above.							
SIGNATURE Wm Mc Lane M.D.		ADDRESS (Street, city, town, state) Frostburg, Md		DATE SIGNED 10-17-59			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/20/1959		NAME OF CEMETERY OR CREMATORY Memorial Park		LOCATION (City, town, or county) (State) Frostburg, Maryland	
24. REC'D BY REGISTRAR OCT 20 '59		REGISTRAR'S SIGNATURE Arthur S. Kraus		25. FUNERAL DIRECTOR'S SIGNATURE GEORGE RICHORN, LONACONING, MD.			
DATE							

1983

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

CERTIFICATE OF DEATH

1983

Age, Sex, Race

1. DECEASED PERSON'S NAME (Last, first, middle)

2. DECEASED PERSON'S ADDRESS (Street, city, state, zip)

3. DECEASED PERSON'S OCCUPATION

4. DECEASED PERSON'S DATE OF BIRTH

5. DECEASED PERSON'S SEX

6. DECEASED PERSON'S RACE

7. DECEASED PERSON'S MARRIAGE STATUS

8. DECEASED PERSON'S ETHNIC ORIGIN

9. DECEASED PERSON'S RELIGION

10. DECEASED PERSON'S PLACE OF BIRTH

11. DECEASED PERSON'S DATE OF DEATH

12. DECEASED PERSON'S PLACE OF DEATH

13. DECEASED PERSON'S CAUSE OF DEATH

14. DECEASED PERSON'S MANNER OF DEATH

15. SIGNATURE OF DECEASED PERSON'S NEXT OF KIN

16. SIGNATURE OF DECEASED PERSON'S PHYSICIAN

17. SIGNATURE OF DECEASED PERSON'S MORTUARY

18. SIGNATURE OF DECEASED PERSON'S BURIAL

19. SIGNATURE OF DECEASED PERSON'S CREMATION

20. SIGNATURE OF DECEASED PERSON'S OTHER

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100. SIGNATURE OF DECEASED PERSON'S OTHER

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY xxx Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West of Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Highway #49		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DORIS LOUISE LEWIS		4. DATE OF DEATH Month Day Year OCTOBER 27 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1940
9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Short Gap, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence VanMeter		14. MOTHER'S MAIDEN NAME Lorena Whitacre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ronald L. Lewis		204 Humbird Street Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED SKULL DUE TO Conditions, if any, which gave rise to immediate cause (b) Automobile Accident (c) 824X DUE TO (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of her car and run over by oncoming car.	
20c. TIME OF INJURY Month, Day, Year 1:50 a.m. Oct. 26 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Rt. # 49	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1 mi. West Cumberland Alleg.		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 27, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 29, 1959	22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery	22d. LOCATION (City, town, or county) (State) Mineral County, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DA 140V 2 '59	
24b. REGISTRAR'S SIGNATURE Carroll E. Hafer			

10871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY BUFFALO MILLS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BUFFALO MILLS 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle MARY Last LEYDIG		4. DATE OF DEATH Month OCTOBER Day 23 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 20 1940
9. AGE (In years lost birthday) 18 yrs.		10. IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER SHAFFER		14. MOTHER'S MAIDEN NAME HELEN GROSSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT WARWICK & MEMORIAL AVENUE		MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LYMPHATIC LEUKEMIA 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 10, 1959 to OCT. 23, 1959 , that I last saw the deceased alive on OCT. 22, 1959 , and that death occurred at 4:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James Jacobson M.D.			
PHYSICIAN'S NAME (Type) DR. S.M. JACOBSON			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct. 26, 1959	Lybarger Cemetery	Buffalo Mills Pa
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler		ADDRESS Hyndman Pa	24a. REC'D BY REGISTRAR DATE OCT 27 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CENTRAL STATE OF DEATH

10831

ALL LEGAL

CUMBERLAND

MEMORIAL HOSPITAL

ANNA

MARY

LEWIS

OCTOBER

23

1955

WHITE

18

PENNSYLVANIA

U.S.A.

WALTER CHAPMAN

MELBA GROSSE

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND
HARRISON & MEMORIAL AVENUE

DECEASED PERSON'S NAME

DR. J. W. JACKSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10866

10872

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Bedford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS Hyndman	
3. NAME OF DECEASED (Type or print) First Betty Middle J. Last Leydig		4. DATE OF DEATH Month October Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1922
9. AGE (In years last birthday) 36		10. IF UNDER 1 YEAR Months 36 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Somerset, Pa.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edmund J. Phillippi		14. MOTHER'S MAIDEN NAME Mary Mae Shaffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 185-12-9370	
17. INFORMANT Donald Leydig, Hyndman, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized abdominal carcinoma. 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 199.2 DUE TO (c) 199.2 DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 weeks		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-23-59 , 19____, to 10-2-59 , 19____, that I last saw the deceased alive on 10-2-59 , 19____, and that death occurred at 2:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyndman, Pa. DATE SIGNED _____			
ACTUAL SIGNATURE John A. Topper		M.D. _____	
PHYSICIAN'S NAME (Type) John A. Topper, M.D.		_____	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Oct. 6, 1959	
22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Therese H. Hughes		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR DATE OCT 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

10835

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18

CERTIFICATE OF DEATH

10835

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

NAME: [illegible]
DATE: [illegible]
LOCATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

10835

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10867

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany County</u> <u>Sacred Heart Hospital</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>		c. LENGTH OF STAY IN 1b <u>5 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mt. Savage</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>Railroad St., P.O. Box 519</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>Teresa</u> Last <u>LONG</u>			4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1955</u>	9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Infant)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
13. FATHER'S NAME <u>Harry W. Long</u>			14. MOTHER'S MAIDEN NAME <u>Iona A. Oss</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Harry W. Long P.O. Box 519 Mt. Savage Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND OF HEAD</u> <u>919.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>919.0</u> DUE TO causing the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Accidentally shot by an eight year old brother</u>					INTERVAL BETWEEN ONSET AND DEATH <u>35 Min.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally shot by an eight year old brother</u>			
20c. TIME OF INJURY Month, Day, Year <u>4:00 p.m. Oct. 26 1959</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>X Home</u>		20f. (City or town) (County) (State) <u>Mt. Savage, Alleg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Geo. Episcopal</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. George</u>	

10874 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN lb <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Anthony</u> Last <u>Luhrman</u>				4. DATE OF DEATH Month <u>10/</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-27-1891</u>	
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Blacksmith</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. Rwy.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Alphonsus Luhrman</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Huffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes,</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>W.W.# 1</u>			
17. INFORMANT <u>Mrs. Helen R. Luhrman</u>				Address <u>Cumberland, Md. 319 Avirett Ave.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic and coronary heart disease 2 years</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10-3</u> , 19 <u>54</u> , to <u>10-17-59</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-17-59</u> , 19 <u> </u> , and that death occurred at <u>2:15M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph W. Ballin</u>				ADDRESS (Street, city or town, state) <u>62 Greene St. Cumberland, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin M.D.</u>				DATE <u>10-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 21 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2028

100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10875

10869

062

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1960

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12-1-25	
5. PLACE OF BIRTH MOBILE, ALA.		6. OCCUPATION None	
7. MARITAL STATUS Single		8. EDUCATION High School	
9. PRESENT ADDRESS Room 306, 400 N. Capitol St., Baltimore, Md.		10. DATE OF DEATH 4-4-68	
11. CAUSE OF DEATH Suicide by gunshot wound of the chest		12. MANNER OF DEATH Homicide	
13. MEDICAL HISTORY None		14. SOCIAL HISTORY None	
15. TOXICOLOGY None		16. AUTOPSY None	
17. SIGNATURE OF EXAMINER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover	
19. OFFICIAL SEAL J. Edgar Hoover		20. OFFICIAL SEAL J. Edgar Hoover	

10876

CERTIFICATE OF DEATH

10870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street or institution) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM LYDEN		4. DATE OF DEATH Month Day Year OCTOBER 28 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 1877
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BARTON, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MICHAEL LYDEN		14. MOTHER'S MAIDEN NAME Sarah Haughton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-16-4880	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left Ventricular Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Posterior myocardial infarction with coronary occlusion DUE TO (c) Coronary Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days ?????	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 21, 1959 to October 28, 1959 that I last saw the deceased alive on October 28, 1959 , and that death occurred at 3:00PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 50 Pershing St. Cumberland, Md. 10/30/59			
ACTUAL SIGNATURE DR. SAMUEL JACOBSON MD.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/59	22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE NOV 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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continued from page 10

52 May 1964

запасов

CERTIFICATE OF DEATH

Reg. Dist. No.

10877

10871

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Mineral ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 4 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Englebert Middle John Last Maiers				4. DATE OF DEATH Month 10/ Day 17 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-31-96	
9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Yard Foreman		11. BIRTHPLACE (State or foreign country) W. Md. Rwy. Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Maiers				14. MOTHER'S MAIDEN NAME Catherine Zetz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, W.W.# 1				16. SOCIAL SECURITY NO. INFORMANT Mrs. Margaret H. Maiers Address Ridgeley, W.VA. 2 Jones St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 578x Goutier - Intestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from June 17, 1955 to Oct 17, 1959 , that I lost sows the deceased alive on Oct 17, 1959 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. M. Schindler M.D. 43				ADDRESS (Street, city or town, state) Cumberland Md 14/11/59 DATE SIGNED			
PHYSICIAN'S NAME (Type) Blaine M. Schindler M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/59		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR OCT 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10871

CERTIFICATE OF DEATH

10871

CHIEF CLERK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10872

10907

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 47 Centennial Street		d. STREET ADDRESS 47 Centennial Street	
3. NAME OF DECEASED (Type or print) First GILES Middle F. Last MAUREY		4. DATE OF DEATH Month 10 Day 23 Year 1959.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1904
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Allegany Ballistics Frostburg	
11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Maurey		14. MOTHER'S MAIDEN NAME Mary Winner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Carmen Maurey, 47 Centennial St.,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 12, 1959 , to Oct 23, 1959 , that I last saw the deceased alive on Oct 12, 1959 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W O M C Lane M.D.		ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED 10/24/59	
PHYSICIAN'S NAME (Type) W O M C Lane M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-26-59	22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montanari		24. REC'D BY REGISTRAR OCT 29 1959	
ADDRESS 23 E. Main, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained for the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10878

10873

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS RT. # 1 BOX 425				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GLEN Middle E. Last MC GILL				4. DATE OF DEATH Month OCTOBER Day 28 Year 19 59			
5. SEX MALE WXXX		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 14	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min.		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Self			
13. FATHER'S NAME EDWARD MC GILL				14. MOTHER'S MAIDEN NAME SUSAN HAINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) NO				16. SOCIAL SECURITY NO. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic O.S.C. V.D. DUE TO Chronic O.S.C. V.D. (c) Chronic O.S.C. V.D.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH approx 7 days approx 10 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JANUARY , 19 51 , to Oct 28 , 19 59 , that I last saw the deceased alive on Oct 28 , 19 59 , and that death occurred at 7:30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE John A Topper				ADDRESS (Street, city or town, state) Hysman Rd DATE SIGNED 10/29/59			
PHYSICIAN'S NAME (Type) DR. JOHN TOPPER MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/30/59		Rose Hill Cem		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Steen Inc. (Cumber) Md.				24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

2580

2000

CERTIFICATE OF DEATH

Reg. Dist. No.

10874

10879

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle REX Last MILLER		4. DATE OF DEATH Month OCTOBER Day 16 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 19, 1898
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk to Supt.		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Shops	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE MILLER (DECEASED)		14. MOTHER'S MAIDEN NAME SUSIE O'Neal (DECEASED)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes,		16. SOCIAL SECURITY NO. W.W.# 1	
17. INFORMANT Address Cumb. Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 147X DUE TO Starvation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Carcinoma Pharyngeal Wall DUE TO 3 1/2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 mo	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from May 15, 1956 , to Oct 16, 1959 , that I last saw the deceased alive on Oct 16, 1959 , and that death occurred at 2:20 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE R. Rhett Rathbone		ADDRESS (Street, city or town, state) 122 So Center St, Cumberland, Md DATE SIGNED 10/16/59	
PHYSICIAN'S NAME (Type) R. Rhett Rathbone M.D.		M.D. 122 So Center St, Cumberland, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/19/59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DCT		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10874

CERTIFICATE OF DEATH

10874

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10880

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.				d. STREET ADDRESS 525 MARYLAND AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle J. Last MORRIS				4. DATE OF DEATH Month OCTOBER Day 18 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/15/1882	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) St. Thomas, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME AMBROSE RICKER				14. MOTHER'S MAIDEN NAME MARGARET CONNOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) any							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/15/59 , 19____, to _____, 19____, that I last saw the deceased alive on 10/18/59 , 19____, and that death occurred at 11:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David T. Rees				ADDRESS (Street, city or town, state) 702 Montgomery Ave			
PHYSICIAN'S NAME (Type) DR. CLAY DORRITT				DATE SIGNED NOV 19 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-59		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR NOV 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10880

ALLIANCE

WILSON

8 DAYS

CHICAGO

105 WYLAND AVE.

MEMORIAL HOSPITAL MEMORIAL AVE.

OCTOBER

1912

ELIZABETH

WHITE

FEMALE

IMMEDIATE CORNER

ANDROS RICKS

MEMORIAL HOSPITAL, CHICAGO, ILL.

11:50 A.M.

10/12/12

10/12/12

10-1-12

10-1-12

10-1-12

10881

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 209 Piedmont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Francis Last O'Neill				4. DATE OF DEATH Month 10 Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/8, -1909	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 24 Days 24 Hours 19 Min.		IF UNDER 24 HRS. Months 24 Days 24 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) News Co. Mgr.				10b. KIND OF BUSINESS OR INDUSTRY News Company		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michael F. O'Neill				14. MOTHER'S MAIDEN NAME Margaret German			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No				16. SOCIAL SECURITY NO. —			
17. INFORMANT Mrs. Christine O'Neill Cumb. Md.				Address Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosis (c) Cirrhosis, liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cataleptosis, rt. lung; Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 10/24				20g. (County) 10/24		20h. (State) 1959	
21. I certify that I attended the deceased from 10/7 , 19 59 , to 10/24 , 19 59 , that I last saw the deceased alive on 10/24 , 19 59 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley Jr.				ADDRESS (Street, city or town, state) 456 N. Centre St.		DATE SIGNED 10/27/59	
PHYSICIAN'S NAME (Type) LEO H. LEY JR.				Cumberland, Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/28/59		22c. NAME OF CEMETERY OR CREMATORY St. P & P. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR DATE OCT 29 1959	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kiser			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wm. Road E. Slope of Irons Mt.		d. STREET ADDRESS 27 Browning Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Paul Last OSTER		4. DATE OF DEATH Month OCTOBER Day 27 Year 1959	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1947	
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 6 grade		10b. KIND OF BUSINESS OR INDUSTRY (Shop Craft)	
11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman V. Oster		14. MOTHER'S MAIDEN NAME Katherine S. Ruby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother Mrs. Katherine Oster		Address 27 Browning	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic asphyxiation DUE TO 822X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pinned under upset vehicle DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pinned under upset vehicle		INTERVAL BETWEEN ONSET AND DEATH 15 Min(?)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pinned under upset vehicle	
20c. TIME OF INJURY Month, Day, Year 10:00 m. Oct. 27 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Williams Rd. Alleg. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Oct. 28, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-59	
22c. NAME OF CEMETERY OR CREMATORY Beanscove Meth.Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR OCT 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1983

1. Name of Deceased [Illegible]		2. Sex [Illegible]	
3. Date of Birth [Illegible]		4. Date of Death [Illegible]	
5. Place of Birth [Illegible]		6. Usual Residence [Illegible]	
7. Cause of Death (Immediate) [Illegible]		8. Cause of Death (Underlying) [Illegible]	
9. Manner of Death [Illegible]		10. Signature of Medical Examiner [Illegible]	
11. Signature of Coroner [Illegible]		12. Signature of Registrar [Illegible]	
13. Signature of Physician [Illegible]		14. Signature of Medical Examiner [Illegible]	
15. Signature of Coroner [Illegible]		16. Signature of Registrar [Illegible]	
17. Signature of Physician [Illegible]		18. Signature of Medical Examiner [Illegible]	
19. Signature of Coroner [Illegible]		20. Signature of Registrar [Illegible]	
21. Signature of Physician [Illegible]		22. Signature of Medical Examiner [Illegible]	
23. Signature of Coroner [Illegible]		24. Signature of Registrar [Illegible]	
25. Signature of Physician [Illegible]		26. Signature of Medical Examiner [Illegible]	
27. Signature of Coroner [Illegible]		28. Signature of Registrar [Illegible]	
29. Signature of Physician [Illegible]		30. Signature of Medical Examiner [Illegible]	
31. Signature of Coroner [Illegible]		32. Signature of Registrar [Illegible]	
33. Signature of Physician [Illegible]		34. Signature of Medical Examiner [Illegible]	
35. Signature of Coroner [Illegible]		36. Signature of Registrar [Illegible]	
37. Signature of Physician [Illegible]		38. Signature of Medical Examiner [Illegible]	
39. Signature of Coroner [Illegible]		40. Signature of Registrar [Illegible]	
41. Signature of Physician [Illegible]		42. Signature of Medical Examiner [Illegible]	
43. Signature of Coroner [Illegible]		44. Signature of Registrar [Illegible]	
45. Signature of Physician [Illegible]		46. Signature of Medical Examiner [Illegible]	
47. Signature of Coroner [Illegible]		48. Signature of Registrar [Illegible]	
49. Signature of Physician [Illegible]		50. Signature of Medical Examiner [Illegible]	
51. Signature of Coroner [Illegible]		52. Signature of Registrar [Illegible]	
53. Signature of Physician [Illegible]		54. Signature of Medical Examiner [Illegible]	
55. Signature of Coroner [Illegible]		56. Signature of Registrar [Illegible]	
57. Signature of Physician [Illegible]		58. Signature of Medical Examiner [Illegible]	
59. Signature of Coroner [Illegible]		60. Signature of Registrar [Illegible]	
61. Signature of Physician [Illegible]		62. Signature of Medical Examiner [Illegible]	
63. Signature of Coroner [Illegible]		64. Signature of Registrar [Illegible]	
65. Signature of Physician [Illegible]		66. Signature of Medical Examiner [Illegible]	
67. Signature of Coroner [Illegible]		68. Signature of Registrar [Illegible]	
69. Signature of Physician [Illegible]		70. Signature of Medical Examiner [Illegible]	
71. Signature of Coroner [Illegible]		72. Signature of Registrar [Illegible]	
73. Signature of Physician [Illegible]		74. Signature of Medical Examiner [Illegible]	
75. Signature of Coroner [Illegible]		76. Signature of Registrar [Illegible]	
77. Signature of Physician [Illegible]		78. Signature of Medical Examiner [Illegible]	
79. Signature of Coroner [Illegible]		80. Signature of Registrar [Illegible]	
81. Signature of Physician [Illegible]		82. Signature of Medical Examiner [Illegible]	
83. Signature of Coroner [Illegible]		84. Signature of Registrar [Illegible]	
85. Signature of Physician [Illegible]		86. Signature of Medical Examiner [Illegible]	
87. Signature of Coroner [Illegible]		88. Signature of Registrar [Illegible]	
89. Signature of Physician [Illegible]		90. Signature of Medical Examiner [Illegible]	
91. Signature of Coroner [Illegible]		92. Signature of Registrar [Illegible]	
93. Signature of Physician [Illegible]		94. Signature of Medical Examiner [Illegible]	
95. Signature of Coroner [Illegible]		96. Signature of Registrar [Illegible]	
97. Signature of Physician [Illegible]		98. Signature of Medical Examiner [Illegible]	
99. Signature of Coroner [Illegible]		100. Signature of Registrar [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10883

CERTIFICATE OF DEATH

10878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle S. Last PARSENIOS				4. DATE OF DEATH Month OCTOBER Day 17 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 24, 1900	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY Restaurant Owner			
11. BIRTHPLACE (State or foreign country) GREECE				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME STEVE PARSENIOS				14. MOTHER'S MAIDEN NAME ATHENA Drekonis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-32-3041			
17. INFORMANT WARWICK & MEMORIAL AVENUE				18. MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 163X DUE TO Carcinoma Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 months (c) 2 months				INTERVAL BETWEEN ONSET AND DEATH 2 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 18 June , 19 59 , to 17 Oct , 19 59 , that I last saw the deceased alive on 17 Oct , 19 59 , and that death occurred at 2:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. T. Rees md				ADDRESS (Street, city or town, state) Cumberland, Md			
DATE SIGNED 19 Oct 59				DATE SIGNED			
PHYSICIAN'S NAME (Type) DR. REES				M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10/19/59		22c. NAME OF CEMETERY OR CREMATORY Zion Memo. Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md				ADDRESS			
24a. REC'D BY REGISTRAR DATE OCT 21 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Page 4

VS A15 (4)
ISM 9/58

10878

STATEMENT OF DEATH

10878

ALLEGANY

WARRIAND

ALLEGANY

CUMBERLAND

8 DAYS

CUMBERLAND

1701 HENDERSON STREET

MEMORIAL HOSPITAL

OCTOBER 17 1959

STEVE PARSENNIS

CECRO

SEPT. 21, 1900

WHITE

MALE

GREECE

RETIRED

ATHENS

STEVE PARSENNIS

WARRIAND & SONS
MEMORIAL HOSPITAL - CUMBERLAND, MD.

BR. REC.

CERTIFICATE OF DEATH

Reg. Dist. No.

10884

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 143 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GLADYS Middle M Last PITZER				4. DATE OF DEATH Month OCT. Day 7 Year 19 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 8 1909		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Health Nurse		10b. KIND OF BUSINESS OR INDUSTRY Public Health		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE APPLE				14. MOTHER'S MAIDEN NAME AGNES LIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-20-5977		INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Carcinoma of cervix DUE TO (c) Byrs						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 5 , 19 59 , to Oct 7 , 19 59 , that I last saw the deceased alive on Oct 7 , 19 59 , and that death occurred at 5 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. E. ENFIELD				ADDRESS (Street, city or town, state) 10/8/59			
PHYSICIAN'S NAME (Type) S. E. ENFIELD				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE William S. Thomas	

CERTIFICATE OF DEATH

1938

WILLIAM

CHICAGO

140 DAYS

CHICAGO

HOSPITAL & NUNAVIC AVE.

301 GRAND AVENUE

CLAY

WYLER

OCT.

APRIL 8 1938

WHITE

U.S.A.

AGED 48

CHICAGO

MEMORIAL HOSPITAL, CHICAGO, ILL.

2.3.38

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10880

Reg. Dist. No.

10908

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b X Frostburg (Rural # 1)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle B Last PLUMMER			4. DATE OF DEATH Month 10/22/1959 Day 19				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/1915		9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Machanic			10b. KIND OF BUSINESS OR INDUSTRY Gilmore		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME Charles Plummer			14. MOTHER'S MAIDEN NAME Jane Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes War # 2			16. SOCIAL SECURITY NO. 213-09-6462		17. INFORMANT Mrs. Margaret Plummer, Gilmore, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (WIFE) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 mos.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-1 , 19 59 , to 10-22 , 19 59 , that I last saw the deceased alive on 10-21 , 19 59 , and that death occurred at 10:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl			ADDRESS (Street, city or town, state) 39 W. Main St. Frostburg, Md		DATE SIGNED 10/25/59		
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/1959		22c. NAME OF CEMETERY OR CREMATORY Old Coney Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONACONING, MD.		24a. REC'D BY REGISTRAR DATE OCT 27 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11850

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

1900

PLACE OF DEATH		Municipality	
County		State	
Date of Death		Time of Death	
Age		Sex	
Race		Marital Status	
Cause of Death		Place of Burial	
Signature of Physician		Signature of Registrar	
Signature of Coroner		Signature of Minister	
Signature of Undertaker		Signature of Burial Society	
Signature of Cemetery		Signature of Church	
Signature of Family		Signature of Friends	
Signature of Neighbors		Signature of Community	
Signature of City		Signature of State	
Signature of Nation		Signature of World	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10909

10881

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 2 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 72 Armstrong Street		d. STREET ADDRESS 72 Armstrong Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Henry Ramus		4. DATE OF DEATH Month Day Year Oct. 12th, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8th, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY B&ORR	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Clara Ramus, 72 Armstrong St. F'bg. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. O. McLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) W. O. McLane		DATE SIGNED Oct 13 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-15-59	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Dussel, Frostburg Md.		24a. REC'D BY REGISTRAR DATE OCT 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10801

10801

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's findings.

1. PATIENT INFORMATION

NAME: [] SEX: [] AGE: []

2. MEDICAL HISTORY

PREVIOUS ILLNESS: []

3. PHYSICAL EXAMINATION

HEAVY: []

4. CAUSE OF DEATH

5. SIGNATURE OF EXAMINER

6. SIGNATURE OF WITNESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle J. Last Rankin		4. DATE OF DEATH Month October Day 31st Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28th, 1885
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Policeman		10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Rankin		14. MOTHER'S MAIDEN NAME Kathern McCready	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-0776	
17. INFORMANT Mrs. Ada Rankin		Address 20 Stoyer St., F'bg. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Circulatory failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Organic heart disease DUE TO 8 yrs. (c) Coronary atherosclerosis & Pulmonary emphysema.		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic insufficiency, Prostatic hypertrophy.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16th Oct., 1959 to 31st Oct., 1959 , that I last saw the deceased alive on 30th Oct., 1959 , and that death occurred at 5:59 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alvin J. Walters M.D.		ADDRESS (Street, city or town, state) 48 Broadway	
PHYSICIAN'S NAME (Type) Alvin Walters,		" Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-59	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

10883

10810

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10883

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X La Vale, Md.</u> d. STREET ADDRESS <u>1931 National Highway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lelia T. Ritter</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 22, 1907</u> 9. AGE (In years last birthday) <u>52</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>13</u> Year <u>1959</u> 13. FATHER'S NAME <u>Morgan Shriver</u> 14. MOTHER'S MAIDEN NAME <u>Mary J. Daatk/houser</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>214-05-5114</u> 17. INFORMANT <u>Kenneth S. Ritter</u> Address <u>La Vale, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure; Pulmonary Congestion</u> <u>274X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Addisons Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 Hrs.</u> Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct 13, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Oct. 16, 1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Restlawn Cemetery</u> 22d. LOCATION (City, town, or county) <u>Cumberland</u> (State) <u>Md</u>		24a. REC'D BY REGISTRAR <u>Oct 15 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stern, Inc. Cumberland, Md.</u> ADDRESS			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10886

CERTIFICATE OF DEATH

Reg. Dist. No.

10884

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle Linwood Last SCHADT		4. DATE OF DEATH Month OCTOBER Day 4 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 21, 1908
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER SCHADT		14. MOTHER'S MAIDEN NAME LOUISA WINDEMUTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-8656	
17. INFORMANT WARWICK & MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatitis acute & chronic 590X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatitis - virus type secondary to pancreatitis DUE TO Acute nephritis and Uremia (c) 6 weeks 5 weeks 6 weeks +		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer with pyloric Stenosis & obstruction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 21, 1959 to Oct 4, 1959 , that I last saw the deceased alive on Oct 3, 1959 , and that death occurred at 12:02 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE WYLIE M. FAW, JR.		ADDRESS (Street, city or town, state) Cumberland Md Oct 4, 1959	
PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW, JR.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/59	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		24a. REC'D BY REGISTRAR Oct 7 '59	
ADDRESS Cumberland Maryland		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

10-84

CERTIFICATE OF DEATH

10886

ALLICANY

WYLLAND

ALLICANY

COBERLIN

11 DAYS

GREENLAND

MEMORIAL HOSPITAL

ST. 11, VALLEY ROAD

OCTOBER

DEATH

LOUIS LAMOND

JANUARY 21, 1908

WHITE

MALE

PLUTON

10-10-10

11, 10-10-10

PETER SCHMIDT

MEMORIAL HOSPITAL - 11, 10-10-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8. See: Birth Cert. et

CERTIFICATE OF DEATH

10885

Reg. Dist. No.

10887

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN lb 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give name of institution) MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 698 FAYETTE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAMELA Middle ANN Last SHIRES		4. DATE OF DEATH Month OCTOBER 22 Day 19 Year 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1954
9. AGE (In years last birthday) FIVE		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 59 Min.	11. IF UNDER 24 HRS. Months 3 Days 19 Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HUGH SHIRES		14. MOTHER'S MAIDEN NAME ADELE WAITKUNAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) neuroblastoma with metastasis to lungs 193.4 DUE TO (b) 3 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) —		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Sept 22, 1959 to October 22, 1959 , that I last saw the deceased alive on October 22, 1959 , and that death occurred at 2:32 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph A. Reiter		ADDRESS (Street, city or town, state) 112 Bedford St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. RALPH REITER MD.		DATE SIGNED 10/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/59	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc - Cumb-Md.		ADDRESS —	
24a. REC'D BY REGISTRAR OCT 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

10887

ALLIANCE

MARYLAND

ALLIANCE

CUMBERLAND

5 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

MEMORIAL &
WARRICK AVENUE

608 FAYETTE ST.

PAUL

ANN

CHILD

OCTOBER 22

WHITE

WHITE

MARCH 20

FIVE

CUMBERLAND, MARYLAND

ABELE WATKINS

WHITE CHURCH

MEMORIAL HOSPITAL

CUMBERLAND, MD.

DR. RALPH BEITER MD.

Attest: I, *[Signature]*, Clerk of the Board of Health, do hereby certify that the foregoing is a true and correct copy of the original record on file in the office of the Board of Health, City of Baltimore, Maryland, this *22nd* day of *October*, 19*22*.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10888

Reg. Dist. No.

10886

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 548 Greene St.				d. STREET ADDRESS 548 Greene St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VELERIA Middle AMELIA Last SMITH				4. DATE OF DEATH Month Oct. Day 14, Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1893		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harmon G. Lehman				14. MOTHER'S MAIDEN NAME Flora Baer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT George E. Smith		Address Beltsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skifarellic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKIFARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		OCTOBER 14, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-1959		22c. NAME OF CEMETERY OR CREMATORY HillCrest Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE OCT 19 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10887

Reg. Dist. No.

10911

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN TB X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Frostburg "Rural"	
3. NAME OF DECEASED (Type or print) William Henry Spiker		4. DATE OF DEATH Month October Day 25 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Spiker		14. MOTHER'S MAIDEN NAME Alice Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Everett Spiker		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 24 h. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic cirrhosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/25/59 to 10/25/59 , that I last saw the deceased alive on 10/25/59 , and that death occurred at 3 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 27, Main St. Lonaconing, Md.	
ACTUAL SIGNATURE George Vash M.D.		DATE SIGNED 10/28/59	
PHYSICIAN'S NAME (Type) George Vash		ADDRESS Lonaconing, Md.	
22a. BURIAL, CREMATION, (city) Burial		22b. DATE THEREOF 10/28/59	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE OCT 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-28-33

Age 35

Male

White

Single

Residence

Occupation

Place of Death

Time of Death

Day of Week

Month

Year

Dec 2, 1933

Male

Residence

Occupation

Place of Death

Time of Death

Day of Week

Month

Year

Age

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

10-28-33

10-28-33

10-28-33

10-28-33

10-28-33

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany 10888 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 5 days 14 hrs. x d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing Md. d. STREET ADDRESS 25 East Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Marie Last Stakem		4. DATE OF DEATH Month 10 Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-91
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Stevenson	
14. MOTHER'S MAIDEN NAME Elizabeth Mackey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Pt.'s Chart Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM, MASSIVE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture right humerus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN 5 days
20a. EXTENSIONAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down cellar steps	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12:30 AM Oct. 2 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Lonaconing, Alleg. Md. (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarolic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarolic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/1959	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George Eukhom Lonaconing Md		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Hume		DATE SIGNED October 7, 1959	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10890

10889

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	c. LENGTH OF STAY IN 1b 45 dys.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hosp.		f. STREET ADDRESS 566 Patterson Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle MANN Last STEELE		4. DATE OF DEATH Month Oct. Day 9, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53	IF UNDER 24 HRS. Hours 53 Min. 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State parole officer Md. State Govt.		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Steele		14. MOTHER'S MAIDEN NAME Agnes Thomson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-16-2141	
17. INFORMANT Mrs. Mary A. Steele		Address Cumberland, Md. 566 Patterson Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism, massive 903.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of left hip DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH Sudden 45 Days
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell On Side Walk	
20c. TIME OF INJURY Month, Day, Year 4:30 P. m. Aug. 25, 1959		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Cumberland, Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED Oct. 9, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/1959	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem.		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY 10891 Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE W.VA. b. COUNTY Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford 85x-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Edward Swauger				4. DATE OF DEATH Month Day Year October 17 1959			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1903	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Swauger				14. MOTHER'S MAIDEN NAME Lillie Hare			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 219-03-9509		17. INFORMANT Address Mrs. Betty Swauger, Wiley Ford, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							
420.1 DUE TO Coronary Sclerosis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) --							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED October 17, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-1959		22c. NAME OF CEMETERY OR CREMATORY Bittinger		22d. LOCATION (City, town, or county) (State) Bittinger, Garrett, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John Newman				ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR OCT 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BULLETIN 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION PRESENT ADDRESS HOME PHONE BUSINESS PHONE SOCIAL SECURITY NUMBER DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF THE MEDICAL EXAMINER ST. LOUIS, MISSOURI		DECEASED NAME SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION PRESENT ADDRESS HOME PHONE BUSINESS PHONE SOCIAL SECURITY NUMBER DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF THE MEDICAL EXAMINER ST. LOUIS, MISSOURI	
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10-COUNTY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section on pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after a death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10912

CERTIFICATE OF DEATH

Reg. Dist. No.

10891

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle C. Last Taccino		4. DATE OF DEATH Month October Day 26th , Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23rd, 1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.	11. IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Taccino		14. MOTHER'S MAIDEN NAME Marie Sicoli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-30-3672	
17. INFORMANT Mrs. Elizabeth Taccino		Address Box 2 Rt. 1, Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Acute Coronary Occlusion DUE TO Advanced Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Diabetes mellitus (b) 2 yrs. - (c) several yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Heart Disease			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 to 10/26 , 19 59 , that I last saw the deceased alive on 10/26 , 19 59 , and that death occurred at 9:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin M. Rothstein M.D.		DATE SIGNED 48 Broadway	
PHYSICIAN'S NAME (Type) Martin M. Rothstein		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-59	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR OCT 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

1988

UNITED STATES OF AMERICA

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				c. LENGTH OF STAY IN 1b 02 Cumberland,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.				d. STREET ADDRESS 131 Paca St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lulu Middle Ann Last Thompson				4. DATE OF DEATH Month October Day 12 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 72	IF UNDER 24 HRS. Hours 72 Min. 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Junction City, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Heffer				14. MOTHER'S MAIDEN NAME Eugenia Oliver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-28-6850		17. INFORMANT Address Mrs. Ray B. Carder Rt. #1 Ridgeley, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (b) hypertensive cardiovascular disease (a), stating the underlying cause last. DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH 26 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.	
				22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR OCT 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		1950-12-25	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Baltimore, Md.		Teacher		Myocardial Infarction		Natural	
Physician		Hospital		Coroner		Medical Examiner	
Dr. J. Smith		St. Mary's Hospital		John Doe		John Doe	
Signature of Physician		Signature of Hospital		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Office of Report	
1950-12-26		10:00 AM		Baltimore, Md.		State Department of Health	

CERTIFICATE OF DEATH

Reg. Dist. No.

10893

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NANNIE Middle L. Last WATKINS				4. DATE OF DEATH Month OCTOBER Day 18 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 5 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own Home Housewife—Own Home				10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JEFFERSON H. MILLER				14. MOTHER'S MAIDEN NAME SARAH MC DONALD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none			
INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MARYLAND			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis & Infarction DUE TO (b) Myocarditis & Hypertension DUE TO (c) 3 days Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. 3 yrs							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Oct 16 , 19 59 , to Oct 18 , 19 59 , that I last saw the deceased alive on Oct 18 , 19 59 , and that death occurred at 3:05 P. from the causes and on the date stated above.							
ACTUAL SIGNATURE clayton J. Durrett				ADDRESS (Street, city or town, state) 236 N. Air Cumberland Rd			
M.D. 10/19/59				DATE SIGNED			
PHYSICIAN'S NAME (Type) DR. CLAY DURRETT				236 N. Air Cumberland Rd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-59		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR Oct 22 59	
				DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10894

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>40 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>949 Maryland Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Amos</u> Last <u>Whitacre</u>				4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 2, 1901</u>	
9. AGE (In years last birthday) yrs. <u>57</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Body and repairman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobiles</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Jacob W. Whitacre</u>				14. MOTHER'S MAIDEN NAME <u>Emily Seaton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>236-03-4353</u>		17. INFORMANT <u>Mrs. Amanda Whitacre</u> <u>949 Maryland Ave, Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Heart Disease,</u> DUE TO (c) <u>Bronchogenic Carcinoma of right lung.</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>4 mo.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> 19. WAS AUTOPSY PERFORMED? <u>NO</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August 13, 1959</u> , to <u>October 7, 1959</u> , that I last saw the deceased alive on <u>October 7, 1959</u> , and that death occurred at <u>3:05 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>140 Bedford Street</u> DATE SIGNED <u>10-7-59</u> ACTUAL SIGNATURE <u>James P. Hallinan M.D.</u> PHYSICIAN'S NAME (Type) <u>James P. Hallinan, M.D.</u> <u>Cumberland, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland (Rural)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> <u>Cumberland Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Travis</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10895

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN 1b <u>45 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>728 Maryland Ave.</u>		d. STREET ADDRESS <u>728 Maryland Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Wint</u> Middle <u>Wigfield</u> Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Conductor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Wigfield</u>		14. MOTHER'S MAIDEN NAME <u>Deborah Shryock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Irvin Lewis, Eckhart, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arterio Sclerotic Hypertensive Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>6 months</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug. 24</u> , 19 <u>59</u> , to <u>Oct. 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 6</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>L. Michael Glick</u> M.D.			
PHYSICIAN'S NAME (Type) <u>L. Michael Glick M.D.</u> <u>126 N. Smallwood St. Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oldtown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10896

CERTIFICATE OF DEATH

10896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 1 761 FAYETTE STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAMIE Middle E. Last WILHELM		4. DATE OF DEATH Month OCTOBER Day 15 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 28, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELI SLIGER		14. MOTHER'S MAIDEN NAME BELLE Hartsauk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT WARWICK & MEMORIAL AVENUE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, abdominal-transverse colon 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Dehydration	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) 20f. (County)		20f. (State)	
21. I certify that I attended the deceased from Jan , 19 59 , to Oct 15 , 19 59 , that I last saw the deceased alive on 14 Oct , 19 59 , and that death occurred at 2:58 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Brinsfield		M.D. 232 Baltimore Ave ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 10/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/59	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Centreville, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George Cumberland, Md.		24a. REC'D BY REGISTRAR OCT 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

10886

ALLEGANY

WYOMING

ALLEGANY

CLEVELAND

11 DAYS

CLEVELAND

101 FAYETTE STREET

MEMORIAL HOSPITAL

OCTOBER 15 1933

E. WILHELM

MALE

FEBRUARY 28, 1901

WHITE

FEMALE

U.S.A.

PENNSYLVANIA

OUR HOME

MEMORIAL HOSPITAL

ELIZABETH

ELIZABETH

WARRIOR MEMORIAL AVENUE

MEMORIAL HOSPITAL - CLEVELAND, OHIO

PHOTO

10/10/33

10/10/33

10/10/33

Charles L. George, Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10897

10913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>G.</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-23-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Shaft, Md.</u>
13. FATHER'S NAME <u>Jacob Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Boden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>216-10-6801</u>	
17. INFORMANT <u>Mrs. Evelyn L. Wilson</u>		Address <u>Frostburg, Md.</u> <u>100 E. Main,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arterial Sclerosis</u> DUE TO (c) <u>Arteriosclerotic - C - V disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3d</u> <u>± 1 yr.</u> <u>± 1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Sclerosis: Generalized arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 17</u> , 19 <u>59</u> , to <u>Oct. 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 21</u> , 19 <u>59</u> , and that death occurred at <u>9 1/2</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frostburg, Maryland.</u> DATE SIGNED <u>10/23/59</u>			
ACTUAL SIGNATURE <u>Frank T. Harrat</u>		M.D. <u>26 W. Mechanic St</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. HARRAT</u>		<u>Frostburg, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Johnson's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rt. #40, Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah H. Wooten</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
ADDRESS <u>Hafer Funeral Home</u> <u>23 E. Main, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10898

10897

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. STREET ADDRESS 24 NORTH WOODLAWN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle R. Last WIMER				4. DATE OF DEATH Month OCTOBER Day 14 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 4, 1882	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) GRANT CO., W. VA.	
13. FATHER'S NAME Hamilton Shobe				14. MOTHER'S MAIDEN NAME JUDY, MARY JANE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,				16. SOCIAL SECURITY NO. None		INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis - gangrenous bowel 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Left iliac thrombosis DUE TO (c) Hypertensive cardio vascular disease 2 type PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerosis, senility INTERVAL BETWEEN ONSET AND DEATH 36 hrs 10 hrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Oct 13 , 19 59 , to Oct 15 , 19 59 , that I last saw the deceased alive on Oct 15 , 19 59 , and that death occurred at 6:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Donald B. Grove				DATE SIGNED 10/16/59			
PHYSICIAN'S NAME (Type) Dr. Donald B. Grove, M.D.				ADDRESS (Street, city or town, state) Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/59		22c. NAME OF CEMETERY OR CREMATORY Harper Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Harmon, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE OCT 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10893

ALLIANCE

MARYLAND

MARYLAND

MARYLAND

LA VILLE, MARYLAND

1 DAY

CINCINNATI, MARYLAND

24 NORTH WOODLAWN

MARYLAND AVE.

GENERAL HOSPITAL

DECEASED

WINTER

11

CHURCH

JANUARY 1, 1900

WHITE

POWELL

GRANT COL. V. W.

11-1-1900

MOLDOON

JUDY, MARY WIFE

RESIDENCE

GENERAL HOSPITAL, CINCINNATI, MARYLAND

11-1-1900

PO

DR. W. H. HARRIS, JR.

1902/189

W. H. HARRIS, JR.

10898 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DUETTA Middle G Last WINTERSTINE				4. DATE OF DEATH Month OCTOBER Day 22 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 20, 1902	
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Sales Lady Clothing Store Keyser, W.Va.				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME THEODORE COMBS				14. MOTHER'S MAIDEN NAME Margaret Combs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-05-6158			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 1 hr. years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 51 , to Oct , 19 57 , that I last saw the deceased alive on Oct 22 , 19 59 , and that death occurred 6:53 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 133 Virginia Ave				DATE SIGNED 10/25/59			
ACTUAL SIGNATURE Dr. G. Overton Himmelwright				M.D. 133 Virginia Ave			
PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT				Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-59		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR OCT 27 '59	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-1000

10898
CERTIFICATE OF DEATH

ALLEGANY WEST VIRGINIA

CUMBERLAND 3 DAYS WHEELER

WARRICK & BROTHERS
HOSPITAL ROOM 142

PT. 1

DEATH WHITE 37
OCTOBER 20 1900
WHEELER

THROUGH COME
WHEELER

WHEELER

WHEELER

WHEELER

WHEELER

WHEELER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany 10899 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MD. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLERSLIE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 16 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First SARAH Middle ANN Last WOLFE		4. DATE OF DEATH Month Oct. Day 5 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 8, 1868
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BEDFORD COUNTY, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY HARTGE		14. MOTHER'S MAIDEN NAME Elizabeth Fink	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL,		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE 420.1 DUE TO CHRONIC MYOCARDITIS Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO CORONARY SCLEROSIS WITH CALCIFICATION, MARKED.			INTERVAL BETWEEN ONSET AND DEATH 16 hrs. ****
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERTROCHANTERIC FRACTURE OF LEFT HIP			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT SMITH'S NURSING HOME, HYNDMAN, PA.	
20c. TIME OF INJURY Month, Day, Year (9:30 a.m. Oct. 4 1959)	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing home	
20f. (City or town) Mann's Choice, Pa.		(County) Bedford, Pa.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Oct. 5, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Smith Cemetery		22d. LOCATION (City, town, or county) Bedford, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey H. Reigles</i> Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE OCT 8 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Fink</i>		24c. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2000

Reg. Dist. No.

10900

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL (If not in hospital, give home address) OR INSTITUTION MEMORIAL HOSPITAL, WARWICK AVES.				d. STREET ADDRESS 48 BROADWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY YATES				4. DATE OF DEATH Month Day Year OCTOBER 11 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 11, 1959	
9. AGE (In years lost birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME ELLIS R. YATES				14. MOTHER'S MAIDEN NAME MR LEAH A. ARNOLD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Previsible Premature c Respiratory 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) & Cardiac Failure DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 8 hrs 58			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Oct , 19 59 , to 12 Oct , 19 59 , that I last saw the deceased alive on 11 Oct , 19 59 , and that death occurred at 10:25 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 Greene St, Cumberland DATE SIGNED 12 Oct ACTUAL SIGNATURE Leland Ransom M.D. PHYSICIAN'S NAME (Type) DR. L. B. RANSOM							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-12-59		22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Durst Funeral Home, Frostburg, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE Oct 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

2060351XV0

10201

CERTIFICATE OF DEATH

10200

ALLEGANY

MARYLAND

ALLEGANY

FROSTBURG

FROSTBURG

111 BROADWAY

GENERAL HOSPITAL, MARION AVENUE

WATER

WATER

OCTOBER 11

OCTOBER 11, 1921

WHITE

MR. LEON A. ARNOLD

ELMER R. WATTS

GENERAL HOSPITAL, FROSTBURG, MD.

GENERAL HOSPITAL, FROSTBURG, MD.

75

58

11 OCT 11 1921

11 OCT 11 1921

11 OCT 11 1921